FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041764

Facility Name: Rosewood Care Center St. Charles

Address: 850 Dunham Road (Number) St. Charles (City) 60174 (Zip Code)

County: Kane

Telephone Number: (630) 443-4400 **Fax #** (630) 443-4460

IDPA ID Number: 431683970001

Date of Initial License for Current Owners: 4/7/1999

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Cindy A. Tefteller **Telephone Number:** (618) 465-7717

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2003 to 6/30/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) Accountant's Compilation Report Attached (Date)
(Print Name and Title) Cindy A. Tefteller
(Firm Name & Address) C.J. Schlosser & Company, L.L.C.
233 East Center Drive, Alton, IL 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center St. Charles # 0041764 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	109	Skilled (SNF)	109	39,894	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	109	TOTALS	109	39,894	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			7,851	7,851	8
9	SNF/PED					9
10	ICF	4,856	15,673		20,529	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,856	15,673	7,851	28,380	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.14%

D. How many bed-hold days during this year were paid by Public Aid?
41 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 6/28/1999

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 6/28/1999 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 38 and days of care provided 7,851

Medicare Intermediary Tri-Span

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/2004 Fiscal Year: 6/30/2004

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center St. Charles # 0041764 **Report Period Beginning:** 7/1/2003 **Ending:** 6/30/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	181,717	17,161	5,535	204,413		204,413		204,413			1
2	Food Purchase		140,086		140,086		140,086	(1,546)	138,540			2
3	Housekeeping	140,084	28,256		168,340		168,340		168,340			3
4	Laundry	33,316	12,066		45,382		45,382		45,382			4
5	Heat and Other Utilities			113,590	113,590		113,590	10	113,600			5
6	Maintenance	25,411	14,594	97,166	137,171		137,171	11,673	148,844			6
7	Other (specify):* Sanitation			7,711	7,711		7,711		7,711			7
8	**TOTAL General Services**	380,528	212,163	224,002	816,693		816,693	10,137	826,830			8
	B. Health Care and Programs											
9	Medical Director			9,345	9,345		9,345		9,345			9
10	Nursing and Medical Records	1,661,099	172,515	285,120	2,118,734		2,118,734		2,118,734			10
10a	Therapy	108,077	2,684	387,158	497,919		497,919	25,516	523,435			10a
11	Activities	60,542	4,219	1,563	66,324		66,324		66,324			11
12	Social Services	50,079	74	1,874	52,027		52,027		52,027			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,879,797	179,492	685,060	2,744,349		2,744,349	25,516	2,769,865			16
	C. General Administration											
17	Administrative			174,100	174,100		174,100	(41,207)	132,893			17
18	Directors Fees											18
19	Professional Services			4,001	4,001		4,001	30,308	34,309			19
20	Dues, Fees, Subscriptions & Promotions			29,019	29,019	2,090	31,109	(6,153)	24,956			20
21	Clerical & General Office Expenses	160,301	35,206	29,370	224,877		224,877	144,483	369,360			21
22	Employee Benefits & Payroll Taxes			269,957	269,957		269,957	27,099	297,056			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,450	2,450	(2,090)	360	293	653			24
25	Other Admin. Staff Transportation			5,180	5,180		5,180	13,932	19,112			25
26	Insurance-Prop.Liab.Malpractice			49,046	49,046		49,046	8,869	57,915			26
27	Other (specify):*											27
28	**TOTAL General Administration**	160,301	35,206	563,123	758,630		758,630	177,624	936,254			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,420,626	426,861	1,472,185	4,319,672		4,319,672	213,277	4,532,949			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Rosewood Care Center St. Charles #0041764 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			1,163	1,163		1,163	219,990	221,153			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			72,249	72,249		72,249	359,546	431,795			32
33	Real Estate Taxes			103,963	103,963		103,963		103,963			33
34	Rent-Facility & Grounds			990,100	990,100		990,100	(978,715)	11,385			34
35	Rent-Equipment & Vehicles			9,092	9,092		9,092		9,092			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,176,567	1,176,567		1,176,567	(399,179)	777,388			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		170,262	21,668	191,930		191,930	(1,624)	190,306			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,842	59,842		59,842		59,842			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		170,262	81,510	251,772		251,772	(1,624)	250,148			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,420,626	597,123	2,730,262	5,748,011		5,748,011	(187,526)	5,560,485			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center St. Charles # 0041764 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,163)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,145)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(4,062)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,624)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(383)	2		13
14	Non-Care Related Interest	(72,249)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,000)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,203)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,255)	20		28
29	Other-Attach Schedule Marketing Salary	(68,604)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (162,688)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(24,838)	Var	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (24,838)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (187,526)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	X		$		38
39						39
40	Gift and Coffee Shops	X				40
41	Barber and Beauty Shops	X				41
42	Laboratory and Radiology	X				42
43	Prescription Drugs	X				43
44	Exceptional Care Program	X				44
45	Other-Attach Schedule	X				45
46	Other-Attach Schedule	X				46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Rosewood Care Center St. Charles

ID# 0041764

Report Period Beginning: 7/1/2003

Ending: 6/30/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Marketing Salary	$ (68,604)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(68,604)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center St. Charles **#** 0041764 **Report Period Beginning:** 7/1/2003 **Ending:** 6/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,546)	0	0	0	0	0	0	0	0	0	0	(1,546)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	10	0	0	0	0	0	0	0	0	10	5
6	Maintenance	0	0	11,673	0	0	0	0	0	0	0	0	11,673	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,546)	0	11,683	0	0	0	0	0	0	0	0	10,137	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	25,516	0	0	0	0	0	0	0	0	0	25,516	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	25,516	0	0	0	0	0	0	0	0	0	25,516	16
	C. General Administration													
17	Administrative	0	(174,100)	132,893	0	0	0	0	0	0	0	0	(41,207)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	30,308	0	0	0	0	0	0	0	0	30,308	19
20	Fees, Subscriptions & Promotions	(7,458)	0	1,305	0	0	0	0	0	0	0	0	(6,153)	20
21	Clerical & General Office Expenses	(75,749)	0	220,232	0	0	0	0	0	0	0	0	144,483	21
22	Employee Benefits & Payroll Taxes	0	0	27,099	0	0	0	0	0	0	0	0	27,099	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	293	0	0	0	0	0	0	0	0	293	24
25	Other Admin. Staff Transportation	0	0	13,932	0	0	0	0	0	0	0	0	13,932	25
26	Insurance-Prop.Liab.Malpractice	0	0	8,869	0	0	0	0	0	0	0	0	8,869	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(83,207)	(174,100)	434,931	0	0	0	0	0	0	0	0	177,624	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(84,753)	(148,584)	446,614	0	0	0	0	0	0	0	0	213,277	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Rosewood Care Center St. Charles **#** 0041764 **Report Period Beginning:** 7/1/2003 **Ending:** 6/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	203,146	16,844	0	0	0	0	0	0	0	0	219,990	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(76,311)	435,857	0	0	0	0	0	0	0	0	0	359,546	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(990,100)	11,385	0	0	0	0	0	0	0	0	(978,715)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(76,311)	(351,097)	28,229	0	0	0	0	0	0	0	0	(399,179)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(1,624)	0	0	0	0	0	0	0	0	0	0	(1,624)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(1,624)	0	0	0	0	0	0	0	0	0	0	(1,624)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(162,688)	(499,681)	474,843	0	0	0	0	0	0	0	0	(187,526)	45

Facility Name & ID Number Rosewood Care Center St. Charles # 0041764 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Larry Vander Maten	75.00%	See Attached List		See Attached List		
Darrell Hoefling	25.00%	See Attached List		See Attached List		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fee	$ 174,100	HSM Management Services, Inc.	100.00%	$	$ (174,100)	1
2	V								2
3	V	10a	Therapy	387,158	Rosewood Therapy Services, Inc.	0.00%	412,674	25,516	3
4	V								4
5	V	34	Rent	990,100	St. Charles Real Estate, L.L.C.	0.00%		(990,100)	5
6	V	30	Depreciation		St. Charles Real Estate, L.L.C.		203,146	203,146	6
7	V	32	Interest		St. Charles Real Estate, L.L.C.		435,857	435,857	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,551,358			$ 1,051,677	$ * (499,681)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center St. Charles # 0041764 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation - Start Up Costs	$	HSM Management Services, Inc.	100.00%	$ 454	$ 454	15
16	V	17	Administrative Salaries - Start Up		HSM Management Services, Inc.	100.00%	2,923	2,923	16
17	V	22	Payroll Taxes - Start Up Costs		HSM Management Services, Inc.	100.00%	220	220	17
18	V	24	Transportation - Start Up Costs		HSM Management Services, Inc.	100.00%	293	293	18
19	V	25	Other Admin Travel - Start Up		HSM Management Services, Inc.	100.00%	1,739	1,739	19
20	V	17	Administrative - Start Up Costs		HSM Management Services, Inc.	100.00%	3,939	3,939	20
21	V	34	Rent - Start Up Costs		HSM Management Services, Inc.	100.00%	154	154	21
22	V								22
23	V	17	See Schedule VIII		HSM Management Services, Inc.	100.00%	126,031	126,031	23
24	V	21	See Schedule VIII		HSM Management Services, Inc.	100.00%	220,232	220,232	24
25	V	22	See Schedule VIII		HSM Management Services, Inc.	100.00%	26,879	26,879	25
26	V	25	See Schedule VIII		HSM Management Services, Inc.	100.00%	12,193	12,193	26
27	V	30	See Schedule VIII		HSM Management Services, Inc.	100.00%	16,390	16,390	27
28	V	34	See Schedule VIII		HSM Management Services, Inc.	100.00%	11,231	11,231	28
29	V	19	See Schedule VIII		HSM Management Services, Inc.	100.00%	30,308	30,308	29
30	V	26	See Schedule VIII		HSM Management Services, Inc.	100.00%	8,869	8,869	30
31	V	6	See Schedule VIII		HSM Management Services, Inc.	100.00%	11,673	11,673	31
32	V	5	See Schedule VIII		HSM Management Services, Inc.	100.00%	10	10	32
33	V	20	See Schedule VIII		HSM Management Services, Inc.	100.00%	1,305	1,305	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 474,843	$ * 474,843	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center St. Charles # 0041764 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Larry Vander Maten	President	Management	75.00	705,474	2	5.87%	Salary	$ 43,963	17-8	1
2	Darrell Hoefling	Vice-President	Management	25.00	417,048	2	5.87%	Salary	25,989	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 69,952		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center St. Charles # 0041764 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HSM Management Services, Inc.
Street Address: 11701 Borman Drive, Suite 315
City / State / Zip Code: St. Louis, MO 63146
Phone Number: (314) 994-9070
Fax Number: (314) 994-9912

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries - Officers	Total Cost	82,623,207	18	$ 1,192,475	$ 1,192,475	4,846,803	$ 69,952	1
2	21	Salaries - Others	Total Cost	82,623,207	18	3,339,865	3,339,865	4,846,803	195,922	2
3	22	Payroll Taxes	Total Cost	82,623,207	18	299,623		4,846,803	17,576	3
4	22	Employee Benefits	Total Cost	82,623,207	18	84,374		4,846,803	4,950	4
5	25	Travel	Total Cost	82,623,207	18	207,846		4,846,803	12,193	5
6	30	Depreciation	Total Cost	82,623,207	18	279,401		4,846,803	16,390	6
7	34	Building Rent	Total Cost	82,623,207	18	191,446		4,846,803	11,231	7
8	19	Professional Services	Total Cost	82,623,207	18	516,651		4,846,803	30,308	8
9	21	Telephone	Total Cost	82,623,207	18	181,396		4,846,803	10,641	9
10	26	Insurance	Total Cost	82,623,207	18	151,190		4,846,803	8,869	10
11	21	Taxes, Licenses, & Ofc Sup	Total Cost	82,623,207	18	233,014		4,846,803	13,669	11
12	6	Maintenance	Total Cost	82,623,207	18	161,460		4,846,803	9,471	12
13	5	Heat & Other Utilities	Total Cost	82,623,207	18	178		4,846,803	10	13
14	20	Dues & Subscriptions	Total Cost	82,623,207	18	22,253		4,846,803	1,305	14
15	17	Direct - Admin	Direct Cost	1	1	56,079	56,079	1	56,079	15
16	17	Direct - Admin	Direct Cost	16	16	945,872	945,872	0	0	16
17	22	Direct - Payroll Taxes	Direct Cost	1	1	4,353		1	4,353	17
18	22	Direct - Payroll Taxes	Direct Cost	12	12	73,418		0	0	18
19	30	Direct - Depreciation	Direct Cost	1	1	0		1	0	19
20	30	Direct - Depreciation	Direct Cost	1	1	2,040		0	0	20
21	25	Direct - Travel	Direct Cost	1	1	0		1	0	21
22	25	Direct - Travel	Direct Cost	1	1	142		0	0	22
23	6	Direct - Maintenance	Direct Cost	1	1	2,202		1	2,202	23
24	6	Direct - Maintenance	Direct Cost	14	14	20,536		0	0	24
25	TOTALS					$ 7,965,814	$ 5,534,291		$ 465,121	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center St. Charles # 0041764 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Allegiant Bank		X	Refinance Mortgage	Varies	11/02	$ 9,231,200	$ 9,231,200	11/13/04	LIBOR+2.	$ 364,187	1
2	Less: Related Party Interest Income Offset										(23,857)	2
3	Less: Interest Income Offset										(4,062)	3
4	Amortization of Loan Fees										22,672	4
5	Allegiant Bank		X		Varies	6/04	1,258,800	1,258,800	11/13/04	LIBOR+2.75%	6,415	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 10,490,000	$ 10,490,000			$ 365,355	9
	B. Non-Facility Related*											
10	Allegiant Bank		X	Refinance Mortgage	Varies	11/02	1,768,800	1,768,800	11/13/04	LIBOR+2.75%	60,768	10
11	Allegiant Bank		X		Varies	6/04	241,200	241,200	11/13/04	LIBOR+2.75%	10,243	11
12	Less: Related Party Interest Income Offset										(4,571)	12
13												13
14	TOTAL Non-Facility Related						$ 2,010,000	$ 2,010,000			$ 66,440	14
15	TOTALS (line 9+line14)						$ 12,500,000	$ 12,500,000			$ 431,795	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 0** **Line # N/A**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Rosewood Care Center St. Charles # 0041764 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	95,902	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	97,936	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,034	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	101,929	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	103,963	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	82,166	8
	2000	83,825	9
	2001	83,678	10
	2002	94,952	11
	2003	100,920	12

2002 Payment = $47,476

2003 Payment = $50,460

Accrual = Balance of 2003 tax bill (50,460) + 1/2 of estimated 2004 tax bill (51,469)

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Center St. Charles COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0041764

CONTACT PERSON REGARDING THIS REPORT Chuck Schmitz

TELEPHONE (314) 994-9070 FAX #: (314) 994-9912

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-26-226-008		$ 100,920.18	$ 100,920.18
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 100,920.18	$ 100,920.18

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Rosewood Care Center St. Charles # 0041764 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,252 B. General Construction Type: Exterior Brick Veneer Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	8.35 Acres	1994	$ 1,714,398	1
2					2
3	TOTALS	#VALUE!		$ 1,714,398	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center St. Charles # 0041764 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	109			1999	$ 5,353,402	$	40	$ 133,835	$ 133,835	$ 669,175	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Site Development			1999	555,639		25	22,226	22,226	111,129	9
10	Automatic Doors			2002	12,016		10	1,202	1,202	3,005	10
11	Convert Private Rooms to Semi-Private			2002	95,679		40	2,392	2,392	5,980	11
12											12
13											13
14											14
15											15
16											16
17											17
18	Facility Leaseholds:										18
19	Computer Cabling			2001	2,895	413	7	413		1,447	19
20	Vinyl Tile Flooring			2004	6,300	750	7	750		750	20
21											21
22											22
23											23
24											24
25											25
26	Leasehold Improvements - Management Company:										26
27	Office Construction/Improvements			1995	449		5			449	27
28	Office Design			1995	41		5			41	28
29	Office Shelving			1996	96		4			96	29
30	Office Expansion			1996	424		4			424	30
31	Office Expansion			1997	1,135		3			1,135	31
32	Office Expansion			1998	640		3			640	32
33	Office Addition			1999	316		3			316	33
34	Door Locks			1999	158		3			158	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rosewood Care Center St. Charles # 0041764 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,029,190	$ 1,163		$ 160,818	$ 159,655	$ 794,745	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rosewood Care Center St. Charles # 0041764 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 489,549	$	$ 52,943	$ 52,943	5-10 Yrs	$ 253,332	71
72	Current Year Purchases	16,123		704	704	5-10 Yrs	704	72
73	Fully Depreciated Assets	52,883					52,883	73
74								74
75	TOTALS	$ 558,555	$	$ 53,647	$ 53,647		$ 306,919	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	HSM Management	Various	Various	$ 33,640	$	$ 6,688	$ 6,688	4 Yrs	$ 13,182	76
77										77
78										78
79										79
80	TOTALS			$ 33,640	$	$ 6,688	$ 6,688		$ 13,182	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,335,783	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,163	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 221,153	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 219,990	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,114,846	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Schedule Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. ____
This amount was calculated by dividing the total amount to be amortized ____
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center St. Charles # 0041764 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

N/A - ONLY HIRE CERTIFIED AIDES
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-8	hrs	$	14,380	$ 171,853	$	14,380	$ 171,853	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		3,442	39,497		3,442	39,497	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-8	hrs		16,644	201,324	2,684	16,644	204,008	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts				154,364		154,364	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Ambulance, Laboratory, Enterals, Other (specify): & X-Ray	39-8				20,044	15,898		35,942	13
14	TOTAL			$	34,466	$ 432,718	$ 172,946	34,466	$ 605,664	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center St. Charles **#** 0041764 **Report Period Beginning:** 7/1/2003 **Ending:** 6/30/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/2004 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 110,748	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,000)	683,752		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,225		6
7	Other Prepaid Expenses	3,268		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 810,993	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	9,195		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(2,197)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,998	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 817,991	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 119,848	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	780,000		29
30	Accrued Salaries Payable	113,201		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,267		31
32	Accrued Real Estate Taxes(Sch.IX-B)	101,929		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	4,000		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,130,245	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,130,245	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (312,254)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 817,991	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Rosewood Care Center St. Charles # 0041764 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (740,396)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (740,396)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	428,142	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 428,142	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (312,254)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center St. Charles # 0041764 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,269,022	1
2	Discounts and Allowances for all Levels	(1,767,832)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,501,190	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,662,302	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,662,302	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,900	13
14	Non-Patient Meals	1,163	14
15	Telephone, Television and Radio	7,145	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 12,208	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,062	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,062	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Lab Discounts	1,624	28
28a	Miscellaneous	1,293	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,917	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,182,679	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	816,693	31
32	Health Care	2,744,349	32
33	General Administration	758,630	33
	B. Capital Expense		
34	Ownership	1,176,567	34
	C. Ancillary Expense		
35	Special Cost Centers	191,930	35
36	Provider Participation Fee	59,842	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,748,011	40
41	**Income before Income Taxes (line 30 minus line 40)****	434,668	41
42	**Income Taxes**	(6,526)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 428,142	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Yes **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Rosewood Care Center St. Charles # 0041764 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,162	2,268	$ 66,513	$ 29.33	1
2	Assistant Director of Nursing	1,539	1,613	44,596	27.65	2
3	Registered Nurses	18,485	19,386	490,564	25.31	3
4	Licensed Practical Nurses	10,798	11,324	244,394	21.58	4
5	Nurse Aides & Orderlies	57,458	60,257	765,011	12.70	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,974	6,265	108,077	17.25	8
9	Activity Director					9
10	Activity Assistants	4,820	5,055	60,542	11.98	10
11	Social Service Workers	3,711	3,892	50,079	12.87	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,720	20,680	181,717	8.79	15
16	Dishwashers					16
17	Maintenance Workers	1,928	2,022	25,411	12.57	17
18	Housekeepers	15,297	16,042	140,084	8.73	18
19	Laundry	4,552	4,774	33,316	6.98	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,461	12,020	160,301	13.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,803	3,988	50,021	12.54	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	161,708	169,586	$ 2,420,626 *	$ 14.27	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	240	$ 5,535	1-3	35
36	Medical Director	Contract	9,345	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	85	1,563	11-3	44
45	Social Service Consultant	105	1,874	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	430	$ 18,317		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	4,414	$ 211,413	10-3	50
51	Licensed Practical Nurses	1,880	73,707	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	6,294	$ 285,120		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Rosewood Care Center St. Charles # 0041764 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Cheryl King	Administrator	0.00%	$ 33,096
Bart Becker	Administrator	0.00%	22,983
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 56,079

B. Administrative - Other

Description	Amount
Management Fees	$ 174,100
TOTAL (agree to Schedule V, line 17, col. 3)	$ 174,100
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company	Accountant/Consultant	$ 3,950
	Legal Fees	51
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 4,001

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 49,920
Unemployment Compensation Insurance	23,425
FICA Taxes	184,140
Employee Health Insurance	6,586
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
HSM Management Allocation	27,099
Tuition Reimbursement	(234)
Employee Relations	2,654
Employee Physicals	3,052
Employee Uniforms	414
TOTAL (agree to Schedule V, line 22, col.8)	$ 297,056

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section Not Applicable		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,090
Advertising: Employee Recruitment	14,560
Health Care Worker Background Check	
(Indicate # of checks performed 56)	675
Promotional Advertising	4,458
Misc. Dues/Subscriptions	6,326
HSM Management Allocation	1,305
Less: Public Relations Expense	(439)
Non-allowable advertising	(764)
Yellow page advertising	(3,255)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,956

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	653
Entertainment Expense	( )
(agree to Sch. V,	
TOTAL line 24, col. 8)	$ 653

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Rosewood Care Center St. Charles # 0041764 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	Schedule Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center St. Charles **#** 0041764 **Report Period Beginning:** 7/1/2003 **Ending:** 6/30/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association - $5,886**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **55,892** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **59,842**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **(1,163)**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

ROSEWOOD CARE CENTER INC. OF ST. CHARLES
IDPH ID #0041764
ATTACHMENT TO SCHEDULE V, LINE 25
6/30/2004

OTHER ADMIN. STAFF TRANSPORTATION:

MILEAGE REIMBURSEMENT**	$ 5,180
	$ 5,180

**ALL MILEAGE REIMBURSEMENTS ARE FOR TRAVEL VOUCHERS SUBMITTED WHICH WERE LESS THAN $250.00 EACH

ROSEWOOD CARE CENTER INC. OF ST. CHARLES
IDPH ID #0041764
ATTACHMENT TO SCHEDULE VII, SECTION A.
6/30/2004

RELATED NURSING HOME:	CITY:
ROSEWOOD CARE CENTER OF ALTON	ALTON, IL
ROSEWOOD CARE CENTER OF EAST PEORIA	EAST PEORIA, IL
ROSEWOOD CARE CENTER OF EDWARDSVILLE	EDWARDSVILLE, IL
ROSEWOOD CARE CENTER OF ELGIN	ELGIN, IL
ROSEWOOD CARE CENTER OF GALESBURG	GALESBURG, IL
ROSEWOOD CARE CENTER OF INVERNESS	INVERNESS, IL
ROSEWOOD CARE CENTER OF JOLIET	JOLIET, IL
ROSEWOOD CARE CENTER OF MOLINE	MOLINE, IL
ROSEWOOD CARE CENTER OF NORTHBROOK	NORTHBROOK, IL
ROSEWOOD CARE CENTER OF PEORIA	PEORIA, IL
ROSEWOOD CARE CENTER OF ROCKFORD	ROCKFORD, IL
ROSEWOOD CARE CENTER OF ST. LOUIS	ST. LOUIS, MO
ROSEWOOD CARE CENTER OF SWANSEA	SWANSEA, IL

OTHER RELATED BUSINESS ENTITIES:	TYPE OF BUSINESS:
HSM MANAGEMENT SERVICES, INC.	MANAGEMENT CO.
ST. CHARLES REAL ESTATE, INC.	REAL ESTATE LSG.
HSM DEVELOPMENT, INC.	DEVELOPMENT CO.
RCC HOLDING COMPANY	HOLDING COMPANY
ROSEWOOD HOME HEALTH	HOME HEALTH CO.
ROSEWOOD THERAPY SERVICES	THERAPY COMPANY